# 2008 INFLUENZA VACCINATION RECORD

*Information about person to receive vaccine* ***(please print)***

Last Name: _____ Age: _____

First Name: _____

Address: _____ City: _____

Date of Birth: _____ (mm/dd/yy) Phone# _____

Parent's Name: _____

School Name: _____

*for office use only , Check if appropriate*

Child needs second dose _____

Assess if child needs second dose _____

Clinic :

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor.

REFUSAL TO RELEASE INFORMATION: I have read or had explained to me the South Dakota Immunization Information System (SDIIS). I understand the benefits of allowing my child's immunization record to be shared with other primary care providers and public health officials. However, if I choose **NOT** to have my child's immunization record shared with other providers I will request a refusal form.

**Check any below that pertain to your child**

_____ Enrolled in Medicaid

_____ Does not have health insurance

_____ American Indian or Alaskan Native

_____ Has health insurance that does not pay for vaccines

| **Please answer the following questions.** | Yes | No | Don't Know |
|---|---|---|---|
| 1.) Is this child ill? | | | |
| 2.) Does this child have an allergy to eggs or to a component of the vaccine? | | | |
| 3.) Has this child ever had a serious reaction to influenza vaccine in the past? | | | |
| 4.) Has this child ever had Guillain-Barré syndrome? | | | |
| 5.) If your child is 8 yrs. of age or younger have they received 2 or more previous flu shots? | | | |

I have been provided a copy of and have read or have had explained to me the information about the diseases and the vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited and ask that the vaccines listed below be given to me or the person named above (for whom I am authorized to make this request.)

Signature (Parent or guardian if a minor) _____ Date _____

**Please provide a phone number where you can be reached on the date of the clinic** _____

***for office use only***

| | Type | Date/Time | Vaccine Manufacturer | Vaccine Lot number | Route | Site | Date of VIS Publication | Signature of person administering vaccine |
|---|---|---|---|---|---|---|---|---|
| INFLUENZA | LAIV | | MedImmune | | NAS | | 7/24/08 | |
| | TIV | | Sanofi Pasteur Inc | | IM | L R Deltoid Thigh | 07/24/08 | |
| | | | Novartis | | | | | |
| | | | GlaxoSmithKline | | | | | |

NOTICE OF PRIVACY PRACTICES - STATE OF SOUTH DAKOTA DEPARTMENT OF HEALTH

If you would like to review the Notice of Privacy Practices, Version I dated 04/14/2003 from the South Dakota Department of Health please refer to website: http://doh.sd.gov/PDF/HIPAANotice.pdf